

Overall payments to a hospice are subject to the cap amount specified in §418.309.

(4) If the number of days of inpatient care furnished to Medicare patients exceeds 20 percent of the total days of hospice care to Medicare patients, the total payment for inpatient care is determined in accordance with the procedures specified in paragraph (f)(5) of this section. That amount is compared to actual payments for inpatient care, and any excess reimbursement must be refunded by the hospice. Overall payments to the hospice are subject to the cap amount specified in §418.309.

(5) If a hospice exceeds the number of inpatient care days described in paragraph (f)(4), the total payment for inpatient care is determined as follows:

(i) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicare patients.

(ii) Multiply this ratio by the total reimbursement for inpatient care made by the intermediary.

(iii) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.

(iv) Add the amounts calculated in paragraphs (f)(5)(ii) and (iii) of this section.

(g) Payment for routine home care, continuous home care, general inpatient care and inpatient respite care is made on the basis of the geographic location where the services are provided.

[48 FR 56026, Dec. 16, 1983, as amended at 56 FR 26919, June 12, 1991; 70 FR 45145, Aug. 4, 2005; 70 FR 70547, Nov. 22, 2005; 72 FR 50228, Aug. 31, 2007; 74 FR 39414, Aug. 6, 2009]

§418.304 Payment for physician and nurse practitioner services.

(a) The following services performed by hospice physicians and nurse practitioners are included in the rates described in §418.302:

(1) General supervisory services of the medical director.

(2) Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

(b) For services not described in paragraph (a) of this section, a specified Medicare contractor pays the hospice an amount equivalent to 100 percent of the physician fee schedule for those physician services furnished by hospice employees or under arrangements with the hospice. Reimbursement for these physician services is included in the amount subject to the hospice payment limit described in §418.309. Services furnished voluntarily by physicians are not reimbursable.

(c) Services of the patient's attending physician, if he or she is not an employee of the hospice or providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the hospice payment limit described in §418.309. These services are paid by the carrier under the procedures in subpart B, part 414 of this chapter.

(d) *Payment for hospice pre-election evaluation and counseling services.* The intermediary makes payment to the hospice for the services established in §418.205. Payment for this service is set at an amount established under the physician fee schedule, for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decision-making of low complexity other than the portion of the amount attributable to the practice expense component. Payment for this pre-election service does not count towards the hospice cap amount.

(e)(1) Effective December 8, 2003, Medicare pays for attending physician services provided by nurse practitioners to Medicare beneficiaries who have elected the hospice benefit and who have selected a nurse practitioner as their attending physician. This applies to nurse practitioners without regard to whether they are hospice employees.

(2) Nurse practitioners may bill and receive payment for services only if the—

(i) Nurse practitioner is the beneficiary's attending physician as defined in §418.3;

(ii) Services are medically reasonable and necessary;

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(iii) Services are performed by a physician in the absence of the nurse practitioner; and

(iv) Services are not related to the certification of terminal illness specified in § 418.22.

(3) Payment for nurse practitioner services are made at 85 percent of the physician fee schedule amount.

[48 FR 56026, Dec. 16, 1983, as amended at 69 FR 66426, Nov. 15, 2004; 70 FR 45145, Aug. 4, 2005; 70 FR 70547, Nov. 22, 2005]

§ 418.306 Determination of payment rates.

(a) *Applicability.* CMS establishes payment rates for each of the categories of hospice care described in § 418.302(b). The rates are established using the methodology described in section 1814(i)(1)(C) of the Act.

(b) *Payment rates.* The payment rates for routine home care and other services included in hospice care are as follows:

(1) The following rates, which are 120 percent of the rates in effect on September 30, 1989, are effective January 1, 1990 through September 30, 1990 and October 21, 1990 through December 31, 1990:

Routine home care	\$75.80
Continuous home care:	
Full rate for 24 hours	442.40
Hourly rate	18.43
Inpatient respite care	78.40
General inpatient care	337.20

(2) Except for the period beginning October 21, 1990, through December 31, 1990, the payment rates for routine home care and other services included in hospice care for Federal fiscal years 1991, 1992, and 1993 and those that begin on or after October 1, 1997, are the payment rates in effect under this paragraph during the previous fiscal year increased by the market basket percentage increase as defined in section 1886(b)(3)(B)(iii) of the Act, otherwise applicable to discharges occurring in the fiscal year. The payment rates for the period beginning October 21, 1990, through December 31, 1990, are the same as those shown in paragraph (b)(1) of this section.

(3) For Federal fiscal years 1994 through 2002, the payment rate is the payment rate in effect during the previous fiscal year increased by a factor

equal to the market basket percentage increase minus—

- (i) 2 percentage points in FY 1994;
- (ii) 1.5 percentage points in FYs 1995 and 1996;
- (iii) 0.5 percentage points in FY 1997; and
- (iv) 1 percentage point in FY 1998 through FY 2002.

(4) For Federal fiscal year 2001, the payment rate is the payment rate in effect during the previous fiscal year increased by a factor equal to the market basket percentage increase plus 5 percentage points. However, this payment rate is effective only for the period April 1, 2001 through September 30, 2001. For the period October 1, 2000 through March 31, 2001, the payment rate is based upon the rule under paragraph (b)(3)(iv) of this section. The payment rate in effect during the period April 1, 2001 through September 30, 2001 is considered the payment rate in effect during fiscal year 2001.

(5) The payment rate for hospice services furnished during fiscal years 2001 and 2002 is increased by an additional 0.5 percent and 0.75 percent, respectively. This additional amount is not included in updating the payment rate as described in paragraph (b)(3) of this section.

(c) *Adjustment for wage differences.* Each hospice's labor market is determined based on definitions of Metropolitan Statistical Areas (MSAs) issued by OMB. CMS will issue annually, in the FEDERAL REGISTER, a hospice wage index based on the most current available CMS hospital wage data, including changes to the definition of MSAs. The urban and rural area geographic classifications are defined in § 412.64(b)(1)(ii)(A) through (C) of this chapter. The payment rates established by CMS are adjusted by the intermediary to reflect local differences in wages according to the revised wage data.

(d) *Federal Register notices.* CMS publishes as a notice in the FEDERAL REGISTER any proposal to change the methodology for determining the payment rates.

[56 FR 26919, June 12, 1991, as amended at 59 FR 26960, May 25, 1994; 62 FR 42882, Aug. 8, 1997; 70 FR 70548, Nov. 22, 2005; 73 FR 46486, Aug. 8, 2008]